reviews

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The Constant Gardener

John le Carré

Hodder and Stoughton, £16.99, pp 508
ISBN 0340 73338 1

Rating: ★★★★

John le Carré is famous for his brilliant espionage novels. Now it seems to him that the vacuum left by the cold war is being filled by the greed of multinational corporations. That makes him despair and led to his new novel—a story about power, lying, corruption, and social responsibility.

It begins with the brutal and unexplained murder in rural Kenya of Tessa Quayle, a radical young lawyer and aid worker married to Justin, a diplomat in the British High Commission in Nairobi. Two Scotland Yard detectives sent to investigate find that she had, without telling her husband, sent the High Commission documents with compelling evidence that Dypraxa, an important new anti-tuberculosis drug, was being unethically tested on Africans. The High Commission and the Foreign Office sweep the problem under the carpet, and the detectives are taken off the job.

Meanwhile, Justin returns to England and secretly pursues the investigation by himself. He assumes a false identity and visits key people with whom Tessa had been in touch—in Germany, Canada, Sudan. He is followed, threatened, and beaten up by mysterious pursuers but gradually pieces together what has been going on.

Dypraxa was discovered by two scientists in the former East Germany and spotted by a messianic wheeler-dealer who used flattery and bribes to have it "fully tested" and registered in Germany, Poland, and Russia. Karel Vita Hudson (KVH), a major multinational drug company based in Vancouver and Basel, buys the molecule and sells the rights to distribute the drug throughout Africa to Three Bees, a British conglomerate and the biggest company in Kenya. KVH plans to test Dypraxa in Africa for two or three years, by which time tuberculosis will have become a huge problem in the West. By then Three Bees is likely to be in financial trouble, and KVH expects to buy it out cheaply. Dodgy trials in Kenya reveal serious toxicity—liver failure, optic nerve damage, and bleeding—but Three Bees "loses" the records, and witnesses are silenced. KVH funds trials in Canada, but when the investigator finds similar effects and tries to publish the data the company vilifies and sacks her.

Le Carré, who helpfully acknowledges his sources in a postscript, is subtle in his handling of the many issues about drugs in poor countries. The story unfolds admirably, and its main characters are convincing and interesting. This is not an anti-industry novel but a splendid thriller that none the less deserves to be taken seriously.

Andrew Herxheimer *London. Consultant, Health Action International, Amsterdam, and former editor of Drug and Therapeutics Bulletin*

Nursing Practice, Policy and Change

Ed Marjorie Gott

Radcliffe Medical Press, £25, pp 222
ISBN 1 85775 351 8

Rating: ★★

With the increasing emphasis on health promotion and disease prevention, shortages of general practitioners, an ageing population, the need to reduce healthcare costs, and a shift to community based care, nurse practitioners—originally introduced in the United States—are joining primary health care teams in various settings around the world. Marjorie Gott defines them as "trained nurses with advanced post-basic education who assume responsibility for health assessment and the management and delivery of services at the first level of a healthcare system."

Gott and colleagues have used a case study approach to illustrate the contributions made by nurses working at advanced practice levels in Britain, the United States, and Australia. The value of case studies is in the level of detail and the depth of analysis. This virtue, however, is also the book's greatest weakness. The presentation of a few cases does not provide the reader with an overall picture of nurse practitioner roles, the educational programmes involved in preparing them, progress in determining suitable credentials, or models of collaborative practice.

In this era of evidence based practice it is insufficient, even in a textbook, to limit the evaluation of effectiveness of nurse practitioners to brief summaries of conclusions from commissioned reports. A chapter critically appraising recent studies, including a meta-analysis, of the effectiveness of nurse practitioners would have been valuable.

Key to the role of nurse practitioners is their ability to use evidence effectively in their practice. Surprisingly, this book makes little mention of the barriers to evidence based practice and the preparation and resources that nurse practitioners will need.

As Gott makes clear, effective collaboration with doctors and other members of the healthcare team is essential for the nurse practitioner role to be successful. She indicates that our track record is poor in this area: "The inter-professional rivalries and 'turf wars' that characterised 20th century healthcare were in no one's long-term interest; and certainly not the patients that the system is meant to serve." The relationship between doctors and nurses, and how this might work more effectively, was recently tackled in the *BMJ*'s theme issue "Doctors and nurses" (15 April 2000).

Perhaps the most compelling "take home" message for me in Gott's book is her analysis of the reasons why the potential of nurses, the largest single occupational group in the healthcare workforce, to shape healthcare policy remains unrealised. The book serves to empower nurses in their advanced practice roles and in the part they can play to influence health policy.

Alba DiCenso *professor, School of Nursing and Department of Clinical Epidemiology and Biostatistics, McMaster University, Canada*

Reviews are rated on a 4 star scale (4=excellent)

FM AM

The Consultants

BBC Radio 4,
2 and 9 January at 8 00 pm

In this radio documentary, producer Edi Stark has provided what appears to be a candid insight into the contemporary experiences of consultants working in medical and surgical specialties in Britain—in Glasgow and London specifically. The preview tape contained the first of two scheduled programmes, the focus of which is the cost to consultants' private lives incurred by massive undertakings within the NHS. Stark trails doctors along the corridors and up the stairs; she eavesdrops at handover time, and in small, untidy offices she samples the ambience of the confessional.

Though the narratives are compelling, and Stark's account is clear and unadorned, what stands out for me is the quality of these consultants' voices—their tense and clipped expression of what upsets them. Any mirth is tinged with anxiety, and at times the interviews and those interviewed invoke a double dose of déjà vu: for the grind of the hospital regime and also for those interviews with survivors of catastrophic experiences, which we may become inured to on television. However, these experiences (of the NHS) will not cease, and as successive interviewees refer elliptically to relationships they've lost or colleagues who have died too soon or children who do not see their parents, we are reminded that a great many clinicians seem to be barely holding on. Just surviving; giving everything to keep the show on the road. As one surgeon remarks towards the end of the programme, "The NHS has had its pound of flesh."

I'm not sure that I would choose to listen to this programme if not required to do so. There is no light at the end of this particular tunnel, and for the second instalment (advertised but not available for preview) we are promised the following: how "next week" consultants will "talk openly about mistakes they've made." If only all sectors of society were so open and confiding.

There is a certain voyeurism implicit in the first programme, comprised, I think, of its intrusion into other people's pain. To know the extent of such pain within the system one would need to know how many consultants Stark had approached to compile these interviews. Certainly, she has assayed many points of view.

Though Stark is sympathetic to these voices, her ire is raised by the question of private practice. Why do those who complain of tiredness, relentless pressure, and a falling away of private life apparently let themselves in for more of the same by practising privately out of hours? As Stark says to one doctor, "People will say he's his own worst enemy." Some of the voices fall away and do not respond. They sound uncomfortable when they decline to state how much they earn.

The Consultants rehearses the ambivalence that is central to many accounts of medicine, proffered from within: depressed voices stating how rewarding it all is. It says something strange, sad, beautiful, or frankly absurd about the human condition that so many are prepared to sacrifice those whom they say they love (at home) for the welfare of strangers they meet in hospitals.

Sean A Spence *senior clinical lecturer in psychiatry, University of Sheffield*

TV

Driving Mum Crazy

Channel 5, Wednesdays at 8 30 pm,
13 December to 10 January

The first series of *Driving Mum Crazy* last January (reviewed *BMJ* 2000;320:388) wasted an opportunity for accurate exploration of issues in child and adolescent mental health. Considerable media and public interest was achieved, however, hence this second series of four programmes about hyperkinetic disorder (attention deficit hyperactivity disorder (ADHD) in the United States). I hoped that the second series would explain that child and adolescent mental health problems, including hyperkinetic disorder, were complex and needed careful dissection of causative biological, psychological, and social strands (which are often unconsciously hidden by the families seeking help).

We were shown children given diagnoses of hyperkinetic disorder, with secondary conduct disorders. Hidden cameras filmed their disordered behaviour. Despondent parents and hopeless, resigned siblings were interviewed. As with the first series, the issue of genuine informed consent of the child subjects was shamefully ignored. Although these patients had diagnoses of hyperkinetic disorder, their disturbed conduct was paramount. I suspect that such children were chosen because their violent outbursts satisfied the voyeuristic instinct of television. Their parents' naive expectations that methylphenidate would magically turn Hyde back to Jekyll went unchallenged. No effort was made to explain how a child with hyperkinetic disorder but without secondary conduct disorder would have presented—after thorough assessment, such children often respond dramatically to psychological and biological treatments.

CHANNEL 5

Hyperkinetic disorder—a complex problem

This series, like the first, ignores the profession of child psychiatry. Although the first episode showed the complexity of the Maudsley resource, the opportunity to translate this supertertiary assessment process for the lay viewer was missed. In the second programme, no assessment process was shown at all. The boy's diagnosis may as well have come from the local oracle. In fact, hyperkinetic disorder is perhaps the most objectively validated psychiatric diagnosis. Accurate rating scales are routinely used for screening, assessment, and follow up. Such standard practice, which occurs in child and adolescent mental health clinics nationwide, could easily have been shown and would have explained how the behaviour of this small group (hyperkinetic disorder affects about 5 in 1000 children) differs from "oppositional" behaviour, which is common and is often misdiagnosed as "hyperactive."

In view of the fact that hyperkinetic disorder and methylphenidate have a high public profile, what this series should have done was to explain what hyperkinetic disorder is, how it is assessed, and what the pros and cons of methylphenidate treatment are. If this series set out to demystify hyperkinetic disorder and Ritalin, it did not succeed.

Iain McClure *consultant child and adolescent psychiatrist, Vale of Leven Hospital, Alexandria*

The milk of human kindness

How to make a simple morality tale out of a complex public health issue

After years of being hated by advocates of breastfeeding, Nestlé and the rest of the baby food industry must have wept with delight at articles in the *Wall Street Journal* last month.

Their early Christmas present came in the form of a front page, lead news story (5 December) and an accompanying editorial in the European edition (6 December), which painted the baby food manufacturers as heroes poised to save African children from certain death.

What was the nature of their heroism? "One major formula maker," said the article, "Wyeth-Ayerst Laboratories Inc, says it stands ready to donate tons of free formula to HIV-infected women. No.1-ranked Nestlé SA says it too would donate, if asked." Such donations, argued the reporters, would stop the transmission of HIV from mothers to their children via infected breast milk, halting the spread of AIDS through sub-Saharan Africa.

All heroic tales need a villain, and this one was no exception. "Unicef," said the paper, "refuses to greenlight the gifts, because it doesn't want to endorse an industry it has long accused of abusive practices in the Third World."

If there was any doubt in readers' minds about the goodies and baddies in this epic struggle for infant health, the headline hit the message home: "African Babies Fall Ill as Unicef Fights Formula Makers." The editorial went further still, blaming Unicef's "feud against the industry" for "killing millions of children."

Formula fever soon spread west across the US, reaching the pages of the *Houston Chronicle* (December 10). Michelle Malkin, a nationally syndicated columnist, cited the *Wall Street Journal* report and accused Unicef's "breast feeding crusade" of "killing the children it's supposed to protect." She also offered her advice to the agency: "There is a very simple solution: feed the babies formula."

A simple battle

In six days, the American dailies had taken a highly contentious health issue—the merits of breast and bottle feeding in the era of AIDS—and turned it into a simple battle between the benevolent corporations and a seemingly malicious international health agency.

Unicef, whose mission is to "advocate for children's rights and help meet their needs" (www.unicef.org), stood charged by the papers of infanticide. How had this issue become so polarised in the eyes of the US media?

The main answer is that Unicef's stance against the formula industry, and the complexities of mother to child transmission of HIV, are both difficult topics to present in a catchy and newsworthy way. Vilifying Unicef was an easy option.

Carole Bellamy, Unicef's executive director, made her position clear in an angry letter to the *Wall Street Journal* (14 December): "You fail to acknowledge," wrote Bellamy, "that Unicef is leading the way in addressing mother to child transmission, and you fail to explain fully why Unicef so strongly supports breastfeeding." Research showed, she said, that formula fed infants were four to six times more likely to die of disease than breast fed infants, and "exclusive breastfeeding can save lives, as many as 1.5 million a year."

A rush to promote formula feeding, she explained, could lead to the spread of other infectious diseases. Unicef's view is that if formula is to be used, it needs to be done in a targeted manner. The organisation is currently piloting projects in 11 countries to offer women HIV testing and counselling, offering formula to those who then chose to use it.

Alfred Ironside, Bellamy's press spokesman, told the *BMJ* that the article "didn't mention that only 5% or less of women in Africa have access to their HIV status, and therefore the idea of distributing formula to prevent mother to child transmission is moot, unless you send it to every woman in Africa—which would be a major public health disaster."

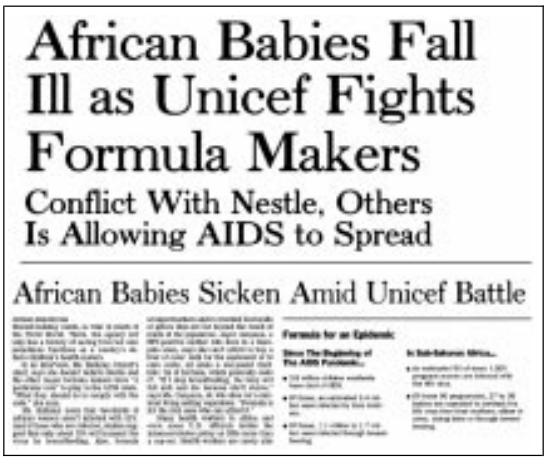
Unicef has been highly vocal in its support for the International Code on the Marketing of Breast Milk Substitutes. It views improper marketing of formula—rather than formula itself—as dangerous, and refuses to accept donations from companies that have violated the code.

But the *Wall Street Journal* marginalised Unicef's policy, focusing instead on the much "racier" tensions between Bellamy and Peter Brabek, Nestlé's chief executive, and Geraldine Ferraro, the former New York vice presidential candidate now employed by Nestlé as a lobbyist.

And in presenting the feud, the newspaper sounded truly exasperated—if only Bellamy would soften her stance, it suggested, and take the corporate gifts on offer, millions now dying would be saved.

Accepting donations sparks controversy

Accepting donations from the formula industry seems to be tearing apart the UN health agencies, adding fuel to the paper's condemnation of Unicef.



African Babies Fall Ill as Unicef Fights Formula Makers

Conflict With Nestle, Others Is Allowing AIDS to Spread

African Babies Sicken Amid Unicef Battle

Was vilifying Unicef the easy option?

"Even some UN officials," said the *Wall Street Journal* reporters, "contend that Unicef's decades-old distrust of the formula industry should yield to a moral imperative to get formula to destitute, HIV-infected mothers."

Who were these officials? None other than Peter Piot, executive director of UNAIDS, the Joint UN Programme on HIV/AIDS, who is quoted as saying that Unicef is "having difficulty accepting that the world has changed."

Perhaps the papers, then, were merely reflecting a growing polarisation of opinion within the UN itself. I put this to Julia Cleves, chief at Dr Piot's office, who told me that Dr Piot's comments were taken out of context, and that the quotation was an oversimplification. "Peter made these comments," she said, "about those in Unicef who pursue a hard line on baby milk, the so-called 'lactation police.' The point is, it wasn't a comment on Unicef as an institution."

But I then spoke to Dr Piot himself, who stood by his attack and expressed frustration that it was taking "too long to find practical solutions" to the HIV crisis. "The solution," he said, "will have to involve both industry and breastfeeding activists." The old mantra of "breast is best," he said, was no longer appropriate. He admitted that "there is a divide across organisations about what is right and wrong, and there are strong feelings."

Despite the attack by Dr Piot, Unicef remains firm in its stance against accepting donations. "The other agencies aren't being offered formula," said Alfred Ironside. "We're the target of these offers and we need a policy to deal with them."

Is the industry cashing in on the crisis?

Many breastfeeding activists say that the formula industry is capitalising on the HIV epidemic to promote its products in the developing world—and the US papers have interpreted this as a charitable mission. Alison Linnear, coordinator of the International Baby Food Network, said, "It would seem that the manufacturers of breastmilk substitutes are seeking to exploit the dilemma posed by HIV/AIDS."

This was certainly the view of the Swiss newspaper *Le Courrier* on 18 December, when it gave its version of events under the headline "Nestlé and its milk powder haven't yet won the battle against AIDS."

"In countries ravaged by AIDS," said the article, written by Robert James Parsons, "children of HIV positive mothers, infected by breast milk, are the target of powdered milk manufacturers who would like to flood southern Africa with their product." His view was that "the *Wall Street Journal* supports the manufacturers."

Dismissing the report, Nestlé's vice president, François-Xavier Perroud, told me: "He [Parsons] is well identified as a breastfeeding advocate," and *Le Courrier* is the "last Marxist rag in Switzerland." He thought, in contrast, that the *Wall Street Journal* article was "well researched and 100% correct." Asked whether Nestlé was trying to cash in on the HIV crisis, he had "no comment."

A missing voice

One voice that was remarkably absent from the *Wall Street Journal* story was that of the World Health Organization. Was it playing hard to get, after recent claims that it has a close relationship with industry? (*BMJ* 2000;320:1362).

In fact, the reporters interviewed many WHO officials, including the director general, Gro Harlem Brundtland, and executive director David Nabarro.

Dr Nabarro told me: "The reporters spent several weeks travelling the world researching the story, and they spoke with some of us for hours at a time. We cannot understand why they wrote what they did."

The journalists, he said, failed to capture the central dilemma facing HIV-infected mothers and their health advisers in Africa: "Risk the death of the infant through HIV infection via breast milk? Or risk the death of the infant through feeding with contaminated supplements? High risk, either way."

He expressed his frustration at the paper for implying that formula donations were the easy answer to a difficult crisis. Donating formula, he said, "does not overcome the problem of shortage of clean water, lack of a fridge, lack of the brushes and soap needed to clean feeding bottles, and shortage of means to boil bottles and sterilise them between feeds."

No apologies from Wall Street

The *Wall Street Journal* rejects the powerful criticisms it has received from the international health community. It makes no apologies whatsoever for the story and the hard hitting editorial, nor for suggesting that donating milk substitutes is the answer to the HIV epidemic. Dick Tofel, a spokesman for the paper, said, "Our view is that these are the facts. If there was more formula available, babies would not be dying."

The procedure is simple: take one very complicated public health issue; add a large dose of scientifically dubious rhetoric; dilute out the complexities. Makes great copy every time.

Gavin Yamey *BMJ*

WEBSITE OF THE WEEK

Drug company ethics John le Carré's new novel (reviewed on p 55) features drug company exploitation of the developing world. In real life as well as in fiction, drug companies are big, powerful, and motivated by money. Médecins Sans Frontières (MSF) has been in the forefront of the campaign to ensure that disadvantaged populations get the medicines they need. Its website www.accessmed.msf.org explains what its campaign is about and exactly what the pharmaceutical industry is up to. It states: "In the pharmaceutical market, profits are put before human lives and life saving medicines are nothing more than commercial products." The "Press clips" option on the home page backs this up and is well worth a read. But be warned, it might disturb you.

The three main thrusts of the campaign are health exceptions to trade agreements, overcoming access barriers, and stimulating research and development for neglected diseases. The site is well organised and has something for both the interested browser and the diehard anti-TRIPS (trade related aspects of intellectual property) campaigner. It also has links to other organisations such as Health Action International (www.haiweb.org), which believes that all marketed drugs should be affordable and meet real medical needs and which also campaigns for better controls on drug promotion.

The ethics of drug trials in the developing world is another hotly debated issue. You can get involved yourself if you go to the Nuffield Council on Bioethics website (www.nuffield.org/bioethics) and download the information pack. Your comments will be considered in the council's report, which will be published later this year. Although the site says contributions will be welcome up to 31 December 2000, I have it on good authority that they will be considered up to the end of January 2001. So get cracking. You can also download the council's discussion paper, "The Ethics of Research in Developing Countries."

After you have checked all this out, you might want to ask yourself whether the money used on that drug lunch sandwich or promotional pen might be better spent elsewhere.

Rhona MacDonald
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NETLINES

- Surgeons in training, especially those in Britain, should visit www.surgical-tutor.org.uk. It offers multiple services, most of good quality and with some nice touches, including biographies of well known surgeons and a section on the thoughts of junior surgeons during recent interviews. There is also a form for others to document what happened at the interview. A good sense of community is on offer here.

- The number of guidelines available has been soaring recently, making it harder to keep track of them all. The web offers an attractive solution to this problem, in particular the site of the Canadian Medical Association at www.cma.ca/cpgs/index.asp. The guidelines are searchable by text, although not all the results are available in full text. There are also a few links, which is particularly useful since no one site contains all the published guidelines. The site's excellent FAQs (frequently asked questions) section is a model of clarity.

- Want to check out what risks certain drugs pose to pregnant women? Well, send your browser in the direction of www.perinatology.com/exposures/druglist.htm. From a simple list system, click on a drug for basic clinical information—just the sort of information that might be needed in a hurry. It is not a comprehensive resource, but a link has thoughtfully been supplied to permit a Medline search with just one click.

- It is always useful for a busy clinician to have services that summarise material from various journals. One such online resource can be found at www.practicalpointers.org. This service is provided free of charge (see www.practicalpointers.org/about.html). The target audience is primary care doctors, but there will be a large general interest in this offering. The site is plain and text based, and some of the papers are not that recent, but it represents a helpful resource, with links to the web based version of the original journal.

- The trip database at www.tripdatabase.com/ is certainly well worth a browse. If you are on the lookout for good quality medical information then this search engine may well be the answer. From a sparse, clutter-free home page whose main feature is the search box, it is easy to search several key resources. A list of these can be found at www.development.sequence.co.uk/tripdatabase/publications.cfm. The search looks only at words in the titles of articles, but, for a rapid literature scan, this is a handy addition to your bookmarks.

Harry Brown *general practitioner, Leeds*
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We welcome suggestions for websites to be included in future Netlines. Readers should contact Harry Brown at the above email address.

PERSONAL VIEW

Africa revisited: a distressing experience

Seven years ago I was infected with HIV in Zambia. Returning to Britain, I continued working as a physician, with the permission of my local health board and following the guidelines of the government's Expert Advisory Group on AIDS, but keeping my HIV secret. Three years later, I wrote to the *BMJ* explaining the reasons for ending this self imposed secrecy (*BMJ* 1996; 312:1679).

Recently my wife and I returned to Zambia under the auspices of Christian Aid to visit some of their AIDS outreach and orphan support projects. Some of these projects are based at the hospital in eastern Zambia where I had worked six years ago. A strong longing to go back there to work was tempered by the reluctant realisation that this was wholly impractical, a view reinforced by my later succumbing to an unpleasant gut infection. Coexisting coeliac disease contributes to my susceptibility to such infections and to my being a rapid progressor, but my virus is held in check by highly active antiretroviral treatment, at great cost to the NHS. My guilt over this is compounded by the fact that infected people in Africa have no hope of benefiting from such treatment in the foreseeable future, and I was fearful of encountering resentment and anger from Zambians. This did not occur.

Seven years ago, in the eastern province, an AIDS outreach programme was under way, with a group of dedicated hospital staff touring the local villages, performing plays, and stimulating discussion in an effort to increase awareness of HIV. Certainly knowledge has improved, but attitudes have not, and much of the stigma and denial persist.

In Zambia, structural adjustment economies imposed by the International Monetary Fund have led to the scrapping of the national tuberculosis surveillance programme. Seven years ago, a good service operated in the eastern province. Defaulters were pursued and encouraged to return to continue their treatment, with excellent results. This activity has had to be curtailed, through staff cutbacks and an irreparable breakdown of the motorcycles and no money to replace them. Petrol and diesel fuel now costs almost as much as in Britain, adding to funding difficulties. But at least the hospital has been able to ensure a regular supply of antituberculosis drugs, which is not the case in many parts of the country.

Earlier attempts to introduce DOTS (directly observed treatment, short course) have had to be abandoned. Some local supervision programmes do exist, mainly organised by non-governmental organisations, but surprisingly they operate independently of AIDS programmes. Given that both diseases are rampantly progressing, there is an obvious need for cooperation. The Zambian government, under severe economic pressure, has largely abandoned responsibility for HIV/AIDS and tuberculosis to the non-governmental organisations.

The United Nations AIDS programme estimates that 33 million people worldwide are living with HIV or AIDS. Of these, 25 million are in sub-Saharan Africa, where 12 million have already died. AIDS in Africa is not merely a medical problem: it is having major socioeconomic effects. Industrial output is falling as a result of the premature death of many skilled workers. The traditional extended family care system has broken down. In Zambia, there are almost half a million AIDS orphans, of a total population of 10 million, and many of these are on the streets, easy prey to exploitation, especially sexual abuse.

> More teachers are dying every day than are being replaced

More teachers are dying every day than are being replaced. Education is suffering, and many children, especially girls, are being withdrawn from school because of unaffordable fees. Poverty or abandonment or both is forcing many women to sell sex in return for food for their families. Lack of respect for female sexual rights, dry sex, poor facilities for the affordable treatment of sexually transmitted disease, unpopularity of the male condom, unavailability of male and female condoms, insufficient research, and development of safe, effective, and acceptable vaginal virucides and vaccines: these and many other factors are contributing to the inexorable progression of the pandemic throughout the Third World.

Is there any hope for Africa? Peter Piot, executive director of UNAIDS, points to recent successes of prevention programmes in Uganda and Senegal, and emphasises that only sustained action by governments at the highest level will prevent regional disasters from developing into a truly global catastrophe. There are signs that the World Bank is at last appreciating the gravity of the situation, but prompt action by the major funding organisations is needed now. Is it too cynical and pessimistic a view that this may not happen until the pandemic starts to hurt the rich North?

A W Logie *retired consultant physician, Melrose, and member of Medact*

If you would like to submit a personal view please send no more than 850 words to the Editor, BMJ, BMA House, Tavistock Square, London WC1H 9JR or email **editor@bmj.com**

SOUNDINGS

My famous friends

I am lucky in that many of my closest friends are really famous people. I first met Johnson on my elective in British Columbia. It was otherwise not a good time in my life. My father had recently died, I had split up with my girlfriend, and the Canadians didn't believe in alcohol. The winter had set in early in the Rockies and I was alone in a small, snowed-in hospital house.

Luckily, I had been introduced to Johnson while I was lying in the bath listening to *Stop the Week* on the evening of my flight to Canada. Robert Robinson recommended a biography by Walter Jackson Bate, which I bought at the airport. Why is he famous, I wondered, staring out of the tiny porthole at the Arctic sky. All he had done was write a few essays and produce a dictionary. It was, I later realised, because his personality—huge, generous, and vulnerable—seemed to span the centuries, the best of humankind, offering hope to us all.

Since then I have met other great men and women. I still have the blue copy of Montaigne's essays that fell from my father's hand as life abruptly fragmented with his fibrillating heart. However, it was some years before I met the 16th century Frenchman in person. I found someone who was ambiguous and ironic, humane and catholic.

Wittgenstein I met through Ray Monk on a wet Eurocamp holiday by the Dordogne—an extraordinary soul, tortured beyond endurance by an unreasonable honesty.

The strange thing is that these people do come to seem like friends, fellow travellers through life. When the going gets tough, you know that they were there before you.

I used to wonder if it was somehow wrong to experience life vicariously—that maybe one should perceive the world unencumbered by another's observations. But the truth is that life is not experienced in its raw state. The familiarity of our own life often deadens our perceptions, and contemplating the lives of these huge figures seems somehow to sensitise us to experiences that are our own, but that otherwise would have passed us by unrecognised.

Not all my friends are dead, although the most articulate of them are. But they have left a legacy of friendship that will last for eternity. And, as Woody Allen observed, eternity is a long time, especially towards the end.

Kevin Barraclough *general practitioner, Painswick, Gloucestershire*